MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3181

CERTIFICATE OF DEATH

Reg. Dist. No. 06154

1) PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE (RURAL)
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-HAVRE DE GRACE R.D.#2
d. STREET ADDRESS: HOME
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: OMA Middle: FAY Last: ARBAUGH

4. DATE OF DEATH: Month: MARCH Day: 9 Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 24, 1937

9. AGE (In years last birthday): 21 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES JOHNSON

14. MOTHER'S MAIDEN NAME: MINERVA E. WILSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: JOSEPH J. ARBAUGH, Address: HAVRE DE GRACE MD R.D.#2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY EMBOLUS — INTERVAL BETWEEN ONSET AND DEATH: 8 days
682X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): THROMBO - PHLEBITIS — 8 days
DUE TO
(c): POST PARTUM

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-14, 1958, to 3-9, 1959, that I last saw the deceased alive on 3-9, 1959, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gunther D. Hirsch M.D. — ADDRESS (Street, city or town, state): 421 CONGRESS AV. — DATE SIGNED

PHYSICIAN'S NAME (Type): GUNTHER D. HIRSCH — HAVRE DE GRACE Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAR. 12 1959
22c. NAME OF CEMETERY OR CREMATORY: MT. ZION CEM.
22d. LOCATION (City, town, or county) (State): HARFORD MD

23. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: HAVRE DE GRACE MD

24a. REC'D BY REGISTRAR DATE: MAR 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3160 CERTIFICATE OF DEATH

Reg. Dist. No. 03155

1. PLACE OF DEATH
a. COUNTY: Har-Ford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hartford Memorial Hosp, Tol

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: HarFord
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen.
d. STREET ADDRESS: 128 Rock. Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ronald Middle Carl Last BarnoFF

4. DATE OF DEATH: Month 3 Day 7 Year 1959.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-3-58

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months 8 Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Eugene Frederick BarnoFF

14. MOTHER'S MAIDEN NAME: EveLyn DiLTs.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: Eugene BarnoFF 128 Rock Rd Abd, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastrointestinal bleeding — INTERVAL BETWEEN ONSET AND DEATH: Termina
DUE TO
(b): Peptic ulcer, acute — 12 hr.
DUE TO
(c): Dehydration, acidosis, chemical imbalance — 1 wk

540.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1958, to 3-7-, 1959, that I last saw the deceased alive on 3-7-A, 1959, and that death occurred at 7:25 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Rodman, M.D. ADDRESS (Street, city or town, state): 8 Law Street DATE SIGNED

PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D. Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/11/59

22c. NAME OF CEMETERY OR CREMATORY: Circle Hill Cemetery

22d. LOCATION (City, town, or county) (State): Fairview, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Barney ADDRESS: Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: MAR 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Friend

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2071274XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3182 **CERTIFICATE OF DEATH** 03156

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rocks
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rocks
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIRGIE Middle ANN Last BLEVINS
4. DATE OF DEATH: Month March Day 25 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 16, 1887
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Harford Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Peter Harman
14. MOTHER'S MAIDEN NAME: ~~XXXXXX~~ Mary B. Steine
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Robert M. Blevins Address: Rocks Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
420.1
DUE TO (b): Coronary Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension and Arteriosclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ---, 19--, to March 24, 1959, that I last saw the deceased alive on March 24, 1959, and that death occurred at 2:?? M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Cardiff, Md. DATE SIGNED: Mar 3/25/59
PHYSICIAN'S NAME (Type): BENJAMIN DOROGI, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/28/1959
22c. NAME OF CEMETERY OR CREMATORY: St. Marys
22d. LOCATION (City, town, or county) (State): Pylesville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hurst ADDRESS: Darlington Md.
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Collins E. Hurst

Items 18&19 Film 242 5-7-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03157

CERTIFICATE OF DEATH

3161 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Aberdeen Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Indiana
b. COUNTY: Unknown
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edinburg
d. STREET ADDRESS: 208 North Kyle Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD Middle RAYMOND Last BRONISZEWSKI

4. DATE OF DEATH: Month March Day 20 Year 19 59

5. SEX: Male
6. COLOR OR RACE: Cau
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 24 October 1922
9. AGE (In years last birthday): 36 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Army
10b. KIND OF BUSINESS OR INDUSTRY: US Army
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: Kasmir D Broniszewski
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII Korean
16. SOCIAL SECURITY NO.: 342-12-0403
17. INFORMANT: Official Army Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 823x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hemorrhage, intraperitoneal and fracture, manebrium
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of vehicle which collided into a tree.
20c. TIME OF INJURY Hour 2:05 a.m. xxx Month, Day, Year: Mar 20 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) Aberdeen (County) Harford (State) Md

21. I certify that I attended the deceased from DOA, 20 Mar, 19 59, to Mar 20, 19 59, that I last saw the deceased alive on never, 19____, and that death occurred at 2:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert L Corn, Capt M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): ROBERT L CORN CAPT MC — USAH, APG, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 3-21-59
22c. NAME OF CEMETERY OR CREMATORY: Edinburg, Indiana
22d. LOCATION (City, town, or county) (State): Edinburg, Indiana

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William Cook-Blight, Inc. Baltimore, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3183 — 03158 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN. (If outside corporate limits, write RURAL and give nearest town): Monkton RD Taylor
c. LENGTH OF STAY IN 1b: 40 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Monkton rural Taylor
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle MATILDA Last Cochran

4. DATE OF DEATH: Month MARCH Day 16 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 31, 1901
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore City, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Theodore Werneke
14. MOTHER'S MAIDEN NAME: Catherine Nabor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -----
16. SOCIAL SECURITY NO.: ----
17. INFORMANT: Harry W. Cochran Address: Monkton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
DUE TO
(b): Laennec's Cirrhosis — 6 mos
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

581.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Cardiovascular Disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1959, to 16 Mar., 1959, that I last saw the deceased alive on 15 Mar., 1959, and that death occurred at 3:55 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thos. A.E. Moseley M.D. ADDRESS (Street, city or town, state): Jarrettsville Md. DATE SIGNED: 3/16/59

PHYSICIAN'S NAME (Type): THOS. A.E. MOSELEY JR. Jarrettsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/18/1959
22c. NAME OF CEMETERY OR CREMATORY: St. Johns
22d. LOCATION (City, town, or county) (State): Hydes Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles C. Hurtt ADDRESS: Jarrettsville Md.
24a. REC'D BY REGISTRAR DATE: MAR 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03159

3162

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 4 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Jarrettsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Fredrick — Last Denbow
4. DATE OF DEATH: Month March — Day 24 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 28, 1869
9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Thomas Denbow
14. MOTHER'S MAIDEN NAME: Catherine Stritehoff
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Willard Denbow, Jarrettsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Head of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: ?
1 7X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr. Cardio-Vascular Disease.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 11, 1959, to March 24, 1959, that I last saw the deceased alive on March 23, 1959, and that death occurred at 8:00 P.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) — DATE SIGNED
ACTUAL SIGNATURE: Willard P. Hudson M.D. Forest Hill, Maryland March 25, 1959
NAME (Type): Willard P. Hudson M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 3/26/1959
22c. NAME OF CEMETERY OR CREMATORY: Bethel
22d. LOCATION (City, town, or county) (State): Madonna Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz — ADDRESS: Jarrettsville, Md.
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Curtis S. Krug

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03160

CERTIFICATE OF DEATH

3163 Reg. Dist. No.

1. PLACE OF DEATH — a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 33 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood Rural
d. STREET ADDRESS: SRB Box 358 Laurel Bush Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle G Last DURMAN
4. DATE OF DEATH: Month MARCH Day 26 Year 1959

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 31, 1915
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: Sand & Gravel
11. BIRTHPLACE (State or foreign country): MAryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES H DURMAN
14. MOTHER'S MAIDEN NAME: MARGARET FOX

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 11
16. SOCIAL SECURITY NO.: 215-05-3873
17. INFORMANT Address: Dorothy M. Durman, Edgewood R.D., Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Chronic Ulcer
DUE TO (b): Bleeding esophageal varices
DUE TO (c): Cirrhosis of Liver

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-21 1959 to 3-25 1959 that I last saw the deceased alive on 3-25 1959, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm K. Brendle M.D. ADDRESS (Street, city or town, state) 610 S. Union Ave,. Havre de Grace,Md., DATE SIGNED 3/26/1959

PHYSICIAN'S NAME (Type): Wm., K. Brendle 610 S. Union Ave., Havre de Grace,Md.,

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/29/1959
22c. NAME OF CEMETERY OR CREMATORY: Southern
22d. LOCATION (City, town or county) (State): Dublin,Harford, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. Williams Jr.
ADDRESS: Abingdon,Md.,
24a. REC'D BY REGISTRAR DATE: MAR 31 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3164 — Reg. Dist. No. 03161

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HALLE DE GRACE
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
d. STREET ADDRESS: 111 Fulford Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FLORENCE — Middle: CAUDILL — Last: EDWARDS

4. DATE OF DEATH: Month: MARCH — Day: 10 — Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN 7 - 1882

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: ✓

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: TYCELL CAUDILL

14. MOTHER'S MAIDEN NAME: CARDINE FENDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ✓ (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Thelma Mann Address: 111 Fulford Ave Bel Air Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO (b): Hypertension and arteriosclerosis — 4 yrs

DUE TO (c): Arteriosclerotic Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/25, 19 59, to 3/10th, 19 59, that I last saw the deceased alive on March 10th, 19 59, and that death occurred at 5:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN: [signature] M.D. — ADDRESS (Street, city or town, state): 211 Union Ave — DATE SIGNED: 3/10/59

PHYSICIAN'S NAME (Type): [illegible] Md, Harford Memorial Hosp, Bel Air, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: MAR 13/59

22c. NAME OF CEMETERY OR CREMATORY: Union Para Baptist

22d. LOCATION (City, town, or county) (State): Sparta Whiteford & N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: 130 Broadway & Williams St. Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 12 '59

24b. REGISTRAR'S SIGNATURE: Arthur B. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3184

CERTIFICATE OF DEATH

03162

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryman
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: #17 Maple Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryman
d. STREET ADDRESS: 17 Maple Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Bertie Middle Lee Last Eichelberger
4. DATE OF DEATH: Month 3 Day 17 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/7/1917
9. AGE (In years last birthday): 42 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10b. KIND OF BUSINESS OR INDUSTRY: Home.
11. BIRTHPLACE (State or foreign country): North Carolina.
12. CITIZEN OF WHAT COUNTRY: USA.

13. FATHER'S NAME: Seymour Ayers
14. MOTHER'S MAIDEN NAME: Nancy Letterman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 241-26-9001
17. INFORMANT: Thomas Robert Eichelberger Address: 17 Maple Ave Perryman Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 MONTH
DUE TO
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): CARCINOMA OF STOMACH — 2 MONTHS
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ASCITES
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/5 19 59 to 3/17 19 59, that I last saw the deceased alive on 3/16 19 59, and that death occurred at 11:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. W. Stewart, Jr. M.D. ADDRESS (Street, city or town, state): Box 95, EDGEWOOD, MD. DATE SIGNED:
PHYSICIAN'S NAME (Type): C. W. STEWART, JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/20/1959
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Garring ADDRESS: Aberdeen, Maryland.
24a. REC'D BY REGISTRAR DATE: MAR 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3165

CERTIFICATE OF DEATH

03163
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 36 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Md — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Belair
d. STREET ADDRESS: 411 S KENMORE St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HENRY — Middle C — Last ENGEL Jr. III
4. DATE OF DEATH: Month March — Day 5 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 31, 1959
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months — Days 34 — IF UNDER 24 HRS. Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? US.
13. FATHER'S NAME: ~~HARRY~~ HENRY C ENGEL JR.
14. MOTHER'S MAIDEN NAME: Ethel BURKINS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17 INFORMANT: HARRY C ENGEL JR Address 411 S KENMORE ST BELAIR HARFORD Co Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CONGENITAL HEART DISEASE
DUE TO (TRUNCUS ARTERIOSUS + INTERVENTRICULAR SEPTAL DEFECT)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/31/59 19__ to 3/8 19 59, that I last saw the deceased alive on 3/7 19 59 and that death occurred at 7:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. K. Brendle MD
ADDRESS (Street, city or town, state): Havre de Grace Md
DATE SIGNED: 3/8/59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Mar 9/59
22c. NAME OF CEMETERY OR CREMATORY: BEL AIR Memorial Gardens
22d. LOCATION (City, town, or county) (State): BEL AIR Harford Md.
23 FUNERAL DIRECTOR'S SIGNATURE: Joseph J. Fiola
ADDRESS: Bel Air Md
24a. REC'D BY REGISTRAR DATE MAR 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krug

2671272XV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3185 — Reg. Dist. No. — 03164

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 401, Moores Mill Rd.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Box 401, Moores Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First DAVID — Middle MADISON — Last ESTES

4. DATE OF DEATH: Month March — Day 14 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 13 Nov. 1880
9 AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumberman
10b. KIND OF BUSINESS OR INDUSTRY: Lumber Business.
11. BIRTHPLACE (State or foreign country): North Carolina
12 CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: John Boone Estes
14. MOTHER'S MAIDEN NAME: Rachel A. Moore

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: 218-32-4169
17. INFORMANT: Mrs. Raymond Howell — Address: Rt #1, Box 176 Joppa, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): HYPERTENSIVE CARDIOVASCULAR DISEASE — 20 years
DUE TO
(c): ARTERIOSCLEROSIS — 3 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 16 19 to March 14 19 59, that I last saw the deceased alive on March 14 19 59, and that death occurred at 1:25 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: Harvey P. Sidwell M.D.
ADDRESS (Street, city or town, state): 401 Franklin St.
DATE SIGNED: March 17
PHYSICIAN'S NAME (Type): Harvey P. Sidwell, M.D. — Bel Air, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 3/16/1959
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Garden,
22d. LOCATION (City, town, or county) (State): Bel Air, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Tarring
ADDRESS: Tarring Funeral Home Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: MAR 18 '59
24b REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3186 CERTIFICATE OF DEATH

Reg. Dist. No. 03166

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Benson
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Road

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Benson, Harford
d. STREET ADDRESS: Harford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anna — Middle N. — Last Hays

4. DATE OF DEATH: Month 3 — Day 25 — Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 20, 1884

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Fallston, Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Noble Mitchell

14. MOTHER'S MAIDEN NAME: Elva Cannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO: --------

17. INFORMANT: Donald H. Hays — Address: Benson, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma left arm with metastases to chest.
199.1

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 7 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ovarium cyst. Prolapse of uterus.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.: ---------- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): ----------

21. I certify that I attended the deceased from January 22, 1938, to March 25, 1959, that I last saw the deceased alive on March 23, 1959, and that death occurred at 12:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifford F. Hudson, M.D. — ADDRESS (Street, city or town, state): Fork, Maryland — DATE SIGNED: 3/25/59

PHYSICIAN'S NAME (Type): Clifford F. Hudson, M.D. — Fork, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/27/59

22c. NAME OF CEMETERY OR CREMATORY: Friendship Methodist

22d. LOCATION (City, town, or county) (State): Fallston, Harford, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03167

3187

CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel-Air
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D. 1 Box # 282

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel-Air
d. STREET ADDRESS: R.F.D. 1 Box # 282
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: B. — Last: Hill

4. DATE OF DEATH: Month: 3 — Day: 14 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 5, 1883

9. AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR: Months: 5 — Days: 9
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Worker + Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Farm + Board of Educ.

11. BIRTHPLACE (State or foreign country): Bel-Air, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Gable Jackson Hill

14. MOTHER'S MAIDEN NAME: Feby Bond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Hattie R. Hill — Address: Rt-1 Box 282, Bel-Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

463X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Phlebitis, Right Leg — 3½ months

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. ., 1947 to Mar. 14, 1959, that I last saw the deceased alive on Mar. 14, 1959, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert Barthel M.D.

ADDRESS (Street, city or town, state): Forest Hill, Md.

DATE SIGNED: 3/14/59

PHYSICIAN'S NAME (Type): Robert Barthel

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-17-59

22c. NAME OF CEMETERY OR CREMATORY: Clark's Chapel Cem.

22d. LOCATION (City, town, or county) (State): Bel-Air, Harford Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Elmer E Bullock — ADDRESS: Havre de Grace

24a. REC'D BY REGISTRAR DATE: MAR 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3168

03168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanede Grace
c. LENGTH OF STAY IN 1b: lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 389 Wilson St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanede Grace
d STREET ADDRESS: 1389 Wilson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Damon — Middle: R. — Last: Hinton
4. DATE OF DEATH: Month: 3 — Day: 18 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 24, 1959
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months: 2 — Days: 22 — IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Hanede Grace, Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: James E. Hinton
14. MOTHER'S MAIDEN NAME: Sylvia Adams
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO —
17. INFORMANT: Address 389 Wilson St. — Rev. James E. Hinton, Hanede Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchial Pneumonia
DUE TO
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan., 1957, to March 18, 1959, that I last saw the deceased alive on March 18, 1959, and that death occurred at 8:30 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: George T. Stansbury, M.D. — ADDRESS (Street, city or town, state): 569 Revolution St. Havre de Grace, Md — DATE SIGNED: 3/20/59

PHYSICIAN'S NAME (Type): George T Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-20-59
22c NAME OF CEMETERY OR CREMATORY: St James Cemetery
22d LOCATION (City, town, or county) (State): Hanede Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Otis J. Bullock. — ADDRESS: Hanede Grace Md
24a. REGISTRAR DATE: MAR 23 '59
24b REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

2071345XV6

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03169

3169 **CERTIFICATE OF DEATH**

Reg. Dist. No. .....

1. PLACE OF DEATH

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air

LENGTH OF STAY (In this place): 52yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 54 Lee St.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air

STREET ADDRESS (If rural give location): 54 Lee St.

3. NAME OF DECEASED (Type or Print): (First) Beatrice (Middle) L. (Last) Howard

4. DATE OF DEATH (Month) 3 (Day) 19 (Year) 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
					Months	Days	Hours	Min.
F	W	W	7/20/1884	74yr yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housework	Baltimore County, Md.	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Albert M. League	Sallie P. Magness

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		214-26-0346	Mrs. Marie H. Reith, 54 Lee St., Bel Air, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A)	Cerebral hemorrhage	12 hours
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B)	Cerebral arteriosclerosis	1 or 2 yrs.
	DUE TO (C)	Arteriosclerotic cardiovascular disease	5 - 8 yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 16, 1959, to March 19, 1959, that I last saw the deceased alive on March 18, 1959, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

SIGNATURE Paul S. Stonesifer Jr. M.D. — **ADDRESS** (Street, city, town, state) 115 Fulford Ave. Bel Air, Md. — **DATE SIGNED** 3/20/59

Paul S. Stonesifer, Jr.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/22/59	Bel Air Memorial Gardens	Bel Air, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
MAR 23 '59	Arthur L. Kraus	Joseph W. Foster	W. Broadway & Williams St. Bel Air, Maryland

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03170

3170 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Bel Air MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Harford
c. LENGTH OF STAY IN 1b 8 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Alice Ann St

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE nd b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air
d. STREET ADDRESS Alice Ann St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mary Middle C Last Johnson
4. DATE OF DEATH Month March Day 19 Year 1959
5. SEX F
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 1 - 1913
9. AGE (In years last birthday) 46 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Bel Air Md
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME S Ridgely Johnson
14. MOTHER'S MAIDEN NAME Blanche Rutt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Y (If yes, give war or dates of service) Y
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Elizabeth J Whittington Address Bel Air Rd 1 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary edema	2 hrs
442X DUE TO (b)	Bronchopneumonia	2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Hypertensive CVR Disease	3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) Gerald C Palmer M.D.
Bel Air, Md DATE SIGNED 3-19-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF MAR 23/59
22c. NAME OF CEMETERY OR CREMATORY Hindon Hill
22d. LOCATION (City, town, or county) (State) Bel Air Harford Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster
ADDRESS W. Broadway + Williams St, Bel Air, Maryland
24a. REC'D BY REGISTRAR DATE MAR 23 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,5 Film G242 5-6-59 et

3166 Now 4 pages

04401

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 3 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
d. STREET ADDRESS: 331 N. OHIO
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY GIRL Middle: Kelley Last: KELLY JR.

4. DATE OF DEATH: Month: MARCH Day: 24 Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: COLORED

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 24, 1959

9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: 3 Min.: 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWBORN Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AMOS MARION KELLY

14. MOTHER'S MAIDEN NAME: FRANCES LORETTA ADAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/24, 19 59, to 3/24, 19 59, that I last saw the deceased alive on 3/24, 19 59, and that death occurred at 10 50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George T. Stansbury, M.D. — ADDRESS (Street, city or town, state): 569 Revolution St. Havre de Grace, Md. — DATE SIGNED: 3/25/59

PHYSICIAN'S NAME (Type): George T. Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify): 22b. DATE THEREOF: 3-24-59

22c. NAME OF CEMETERY OR CREMATORY: HARFORD MEMORIAL HOSPITAL

22d. LOCATION (City, town, or county) (State): Havre de Grace Md

23. FUNERAL DIRECTOR'S SIGNATURE: Harry R. Zell, Jr. Funeral Director — ADDRESS:

24a. REC'D BY REGISTRAR DATE: MAR 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3167

CERTIFICATE OF DEATH

03165

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 40 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE Maryland
b COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d STREET ADDRESS 833 Erie
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Antoni Middle — Last Iannone
4. DATE OF DEATH Month 3 Day 12 Year 59 19
5 SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ ? DIVORCED ☐
8 DATE OF BIRTH 10/3/1876
9 AGE (In years last birthday) 82 yrs
IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS Hours — Min. —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b KIND OF BUSINESS OR INDUSTRY Stone Quary
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Patrick Iannone
14. MOTHER'S MAIDEN NAME Angelia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO. Unknown
17 INFORMANT Elizabeth Iannone, Address 833 Erie Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: One Hr
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Coronary Occlusion — One Day
DUE TO
(c) Hypertensive Arteriosclerotic Disease — 10 Yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑
Diabetes Mellitus

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour — a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/10, 1959, to 3/12, 1959, that I last saw the deceased alive on 3/12, 1959, and that death occurred at 8:40 M, from the causes and on the date stated above

ACTUAL SIGNATURE Irwin R. Ross M.D.
ADDRESS (Street, city or town, state) 200 N Union Ave
DATE SIGNED 3/15/59
PHYSICIAN'S NAME (Type) IRWIN R. ROSS
Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/16/59
22c NAME OF CEMETERY OR CREMATORY Mt. Erin
22d LOCATION (City, town, or county) (State) Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE & ADDRESS Jennings & Son Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE MAR 18 '59
24b REGISTRAR'S SIGNATURE Arthur S. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3171 **CERTIFICATE OF DEATH** Reg. Dist. No. 03171

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 9 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen
d STREET ADDRESS Taylor's Trailer Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last McFadden
4. DATE OF DEATH Month March Day 1 Year 1959
5. SEX male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 1, 1959
9. AGE (In years last birthday) yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours 9 Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?
13 FATHER'S NAME Lawrence McFadden
14 MOTHER'S MAIDEN NAME Edith Boyle
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mother Address Lawrence Trailer Park -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH hrs
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 776X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-1-, 19 59, to 3-1-, 19 59, that I last saw the deceased alive on [illegible], 19 59, and that death occurred at [illegible] M, from the causes and on the date stated above.
ACTUAL SIGNATURE [illegible] M.D. ADDRESS (Street, city or town, state) [illegible] DATE SIGNED 3-1-59
PHYSICIAN'S NAME (Type) Peter P. Kodman M.D. Aberdeen Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF 3-1-59
22c NAME OF CEMETERY OR CREMATORY Harford Memorial Hospital
22d LOCATION (City, town, or county) (State) Havre de Grace, Md

23. FUNERAL DIRECTOR'S SIGNATURE Harry Reilly Administrator ADDRESS
24a. REC'D BY REGISTRAR DATE MAR 10 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be affixed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3183 **CERTIFICATE OF DEATH** 03172

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CARDIFF
c. LENGTH OF STAY IN 1b: 61 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CARDIFF
d. STREET ADDRESS: MAIN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First CORA — Middle MAE — Last NEAL

4 DATE OF DEATH: Month MAR. — Day 5, — Year 1959

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: APR. 27, 1876

9 AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): NEW PARK, PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE W. HARMON

14 MOTHER'S MAIDEN NAME: SUSAN DUSTAN

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16 SOCIAL SECURITY NO.:

17. INFORMANT — Address: THOMAS NEAL, CARDIFF, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis
DUE TO (b): Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19[illegible] to Mar. 5, 19[illegible], that I last saw the deceased alive on Mar. 4, 1959, and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. Cardiff, Md.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S NAME (Type): BENJAMIN DOROGI, M.D. — BENJAMIN [illegible]OGI, M.D. [illegible], Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-8-59

22c NAME OF CEMETERY OR CREMATORY: SLATE RIDGE

22d LOCATION (City, town, or county) (State): DELTA, PA.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Hawkins — ADDRESS: Delta, Pa.

24a. REC'D BY REGISTRAR DATE: MAR 10 '59

24b REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3189

CERTIFICATE OF DEATH

03173

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] Hosp.
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Hill Rt #2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): LENORA [redacted] Middle PALMER Last

4. DATE OF DEATH: Month MAY Day 21 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 22, 1880

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Harford County, Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: [illegible]

17. INFORMANT: Levi Palmer — Address: White Hall Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.

491x

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 21, 1959 to Mar. 21, 1959 that I last saw the deceased alive on Mar. 20, 1959, and that death occurred at 4:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. M. France M.D. ADDRESS (Street, city or town, state): Parkton, Md DATE SIGNED: 3/21/59

PHYSICIAN'S NAME (Type): A. M. FRANCE

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/24/1959

22c. NAME OF CEMETERY OR CREMATORY: [illegible]

22d. LOCATION (City, town, or county) (State): [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz ADDRESS: Jarrettsville, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3172

CERTIFICATE OF DEATH

03174

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — STATE: Maryland — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 39 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ---------

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace, Md.
d. STREET ADDRESS: 870 Ontario
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle G. Last Pascuzzi

4. DATE OF DEATH: Month 3/2I Day Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/5/I883

9. AGE (In years last birthday): 76 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Italy

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Anthony Glorioso

14. MOTHER'S MAIDEN NAME: Josephine Saia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO: Unknown

17. INFORMANT: Emil Rochet — Address: 806 S. Union Ave. Havre de Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Arteriosclerotic C-V Disease — 8 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Diabetes Mellitus — 15 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Osteo-porosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 19 57 to March 19 59, that I last saw the deceased alive on March 20, 19 59, and that death occurred at 8:10 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: J. Ralph Horky M.D. — ADDRESS (Street, city or town, state): Churchville Md — DATE SIGNED: March 24

PHYSICIAN'S NAME (Type): J. Ralph Horky, Churchville, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/24/59

22c. NAME OF CEMETERY OR CREMATORY: St. Vincents

22d LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Pennington & Son, Havre de Grace, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 24 '59

24b REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3173 CERTIFICATE OF DEATH

Reg. Dist. No. 03175

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: HARFORD

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 1½ Days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.
d. STREET ADDRESS: DEL HAVEN TRAILER CRT.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HOWARD Middle: MELVIN Last: REYNOLDS
4. DATE OF DEATH: Month: MARCH Day: 18 Year: 19 59

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 4 1901
9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DESIGNER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DEVILLE REYNOLDS
14. MOTHER'S MAIDEN NAME: MINNIE WALLACE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 163-12-1687
17. INFORMANT: MRS NORA PIERCE REYNOLDS Address: 5 Hickory Rd Balto Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Rheumatic and arteriosclerotic heart disease — 5 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic pneumonia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 17th 19 59 to March 18th 19 59 that I last saw the deceased alive on March 18th 19 59 and that death occurred at 11:40 P M, from the causes and on the date stated above.
ACTUAL SIGNATURE: Edward C Loo M D
ADDRESS (Street, city or town, state): 211 N. Union Ave
DATE SIGNED: 3/18/59
PHYSICIAN'S NAME (Type): Edward C. Loo, M.D. Havre de Grace, Md. 11:45 PM

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: MAR 22/59
22c. NAME OF CEMETERY OR CREMATORY: Mt Zion Methodist
22d. LOCATION (City, town, or county) (State): Fountain Green HARFORD Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster
ADDRESS: W Broadway & Williams St Bel Air, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinnard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 filled-0 4-2-59 et

3190

CERTIFICATE OF DEATH

Reg. Dist. No. 03176

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Joppa

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 154 Reckord Road

d. STREET ADDRESS: Box 154 Reckord Road

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Mr. Howard Middle: Lost: Ruppert

4. DATE OF DEATH: Month: March Day: 26th Year: 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: March 21, 1884

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rt. Service Station Owner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Ruppert

14. MOTHER'S MAIDEN NAME: Gertrude Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Marie Hoerr, 30 Blister St. #20

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.

DUE TO (b): Hypertensive Cardiovascular Dis. — 5 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/5/57, 19, to 3/26, 19 57, that I last saw the deceased alive on 3/26, 19 59, and that death occurred at 1.9 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE, M.D.: Clifford F. Hudson, M.D. ADDRESS (Street, city or town, state): Fork Md. DATE SIGNED:

PHYSICIAN'S NAME (Type): CLIFFORD F. HUDSON, FORK, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/28/59

22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Leonard J. Ruck 5305 Harford Road #14

24a. RECD BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3174

CERTIFICATE OF DEATH

Reg. Dist. No. 03177

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hosp

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Richard — Middle: — Last: Savage
4. DATE OF DEATH: Month: March — Day: 9 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 7 1959
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months: — Days: 1
IF UNDER 24 HRS: Hours: 22 — Min: 50

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): INFANT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Savage
14. MOTHER'S MAIDEN NAME: Mary Martha C. Christensen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Atelectasis & Secondary Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-7, 1959, to 3-9, 1959, that I last saw the deceased alive on 3-8, 1959, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): [illegible] — DATE SIGNED: 3-10-59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 3-10-59
22c. NAME OF CEMETERY OR CREMATORY: Methodist
22d LOCATION (City, town or county) (State): North East Md

23 FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant — ADDRESS: North East Md

24a REC'D BY REGISTRAR DATE: MAR 11 '59
24b REGISTRAR'S SIGNATURE: Clifton L. Knaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3175 — Reg. Dist. No. 03178

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Park Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: Park Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Gordon — Middle: A. — Last: Steele
4. DATE OF DEATH: Month: March — Day: 6 — Year: 19 59

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 28, 1900
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Auto Industry
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 157-10-1557
17. INFORMANT: Gordon F. Steele — Address: 24 Aber. Ave. Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): G S W Cerebrum — INTERVAL BETWEEN ONSET AND DEATH:
476X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self with .22 rifle
20c. TIME OF INJURY Hour: a. m. p. m. — Month, Day, Year: 3-6 19 59
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Aberdeen (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
Bel Air, Md DATE SIGNED: 3-6-59
EXAMINER'S NAME (Type): Gerald C Palmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/9/59
22c. NAME OF CEMETERY OR CREMATORY: Bakers Cemetery
22d. LOCATION (City, town, or county) (State): R.D. Aberdeen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Sherrard — ADDRESS: Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: MAR 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Page 6 is for burial, cremation or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1SME(5)
5M 11/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3176

CERTIFICATE OF DEATH

03179

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Lone Pine Trailer Court

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Lone Pine Trailer Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: J — Last: Thomas

4. DATE OF DEATH: Month: March — Day: 27 — Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 9 1909

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman Penn's Fence Construction

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Gettysburg, Pa

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Thomas

14. MOTHER'S MAIDEN NAME: Emma Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 176-07-7649

17. INFORMANT: Mistress H Thomas — Address: Bel Air Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma larynx — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-15, 1959 to 3-27, 1959 that I last saw the deceased alive on 3-24, 1959, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gerald C Palmer M.D.
ADDRESS (Street, city or town, state): Bel Air Md
DATE SIGNED: 3-27-59

PHYSICIAN'S NAME (Type): Gerald C Palmer-MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/30/59
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air Harford Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph J Foster
ADDRESS: Bel Air Md

24a. RECD BY REGISTRAR DATE: MAR 31 '59
24b. REGISTRAR'S SIGNATURE: Clifton L Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3177

CERTIFICATE OF DEATH

Reg. Dist. No. 03180

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 46 Norman Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 46 Norman Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMETT; Middle D.; Last TOBIN

4. DATE OF DEATH: Month March; Day 23; Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 3, 1910

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Alfred Tobin

14. MOTHER'S MAIDEN NAME: DeXne Jacobs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-2

16. SOCIAL SECURITY NO: 215-05-3303

17. INFORMANT: Mrs. Emmett Tobin — Address 46 Norman Ave. Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: One hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Insufficiency
DUE TO (c): Overweight.

4'

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Peptic Ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 10, 1959 to March 23, 1959 that I last saw the deceased alive on March 23, 1959, and that death occurred at 6:15 PM from the causes and on the date stated above.

ACTUAL SIGNATURE: Andre Weiss M.D.
ADDRESS (Street, city or town, state): 116 W. Bel Air Ave.
DATE SIGNED: 3-24-59

PHYSICIAN'S NAME (Type): Andre Weiss, M.D. Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/26/59
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens,
22d. LOCATION (City, town, or county) (State): Bel Air, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring
ADDRESS: Tarring Funeral Home Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3191

CERTIFICATE OF DEATH

03181

Reg. Dist. No

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cardiff
c. LENGTH OF STAY IN 1b: 2years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cardiff
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First David Middle Columbus Last Watson, Sr.

4. DATE OF DEATH: Month March Day 29, Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 5,1900

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Dairy

11. BIRTHPLACE (State or foreign country): Comers Rock, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Watson

14. MOTHER'S MAIDEN NAME: Minnie A. Parks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-30-3866

17. INFORMANT: Address: Mrs. Dorothy E. Watson, Cardiff, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: 3days-
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year: Hour 8:00 a. m. 1959

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Cardiff (City or town) Harford (County) Md. (State)

21. I certify that I attended the deceased from 25 Mar, 1959, to 29 Mar, 1959, that I last saw the deceased alive on 29 Mar, 1959, and that death occurred at 8:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin W. Whiteford Jr M D. M.D. — ADDRESS (Street, city or town, state): Whiteford, Maryland — DATE SIGNED: 29 Mar 59

PHYSICIAN'S NAME (Type): Edwin W. Whiteford, Jr. — Whiteford, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-1-1959

22c. NAME OF CEMETERY OR CREMATORY: Belair Gardens

22d. LOCATION (City, town, or county) (State): Belair, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John H Hawkins — ADDRESS: Delta, Penna.

24a. REC'D BY REGISTRAR DATE: APR 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3178

CERTIFICATE OF DEATH

03182

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 14 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: P.O. Box 171
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Wheelock

4. DATE OF DEATH: Month: March — Day: 22 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 21, 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours: 14 | Min: 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Bonny Edgar Wheelock

14 MOTHER'S MAIDEN NAME: Elizabeth Honaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: Father — Address: P.O. Box 171 Havre de Grace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Respiratory failure —

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Prematurity (Weight 2 lbs 6 ozs)

DUE TO

(c): Placental abnormalities —

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-21- 1959, to 3-22 1959, that I last saw the deceased alive on 3-21-59 19, and that death occurred at 7:30 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/24/59

22c NAME OF CEMETERY OR CREMATORY: Angel Hill

22d LOCATION (City, town, or county) (State): Havre de Grace, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son

ADDRESS: Havre de Grace Md

24a. REC'D BY REGISTRAR DATE: MAR 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

D-71322 X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3179

CERTIFICATE OF DEATH

03183

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: BELAIR HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BELAIR
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD CONVALESCENT HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): COCKEYSVILLE 03x-2
d. STREET ADDRESS: GLENMORE AVE-COCKEYSVILLE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIE Middle E. Last WHITE

4. DATE OF DEATH: Month MARCH Day 13 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-17-1892
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DISHWASHER
10b. KIND OF BUSINESS OR INDUSTRY: HOTEL
11. BIRTHPLACE (State or foreign country): QUEENSANNE CO., MD
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN CLAYTON
14. MOTHER'S MAIDEN NAME: LILLIE SPARKS.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-16-7645
17. INFORMANT: Address: MRS. WISE BOLT GLENMORE AVE- COCKEYSVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO (b): Hypertensive Cardiovascular Dis. — 9 yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/19 19 52 to 3/13 19 59, that I last saw the deceased alive on 3/12 19 59, and that death occurred at 4 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifford F. Hudson M.D. ADDRESS (Street, city or town, state): Fork Md. DATE SIGNED
PHYSICIAN'S NAME (Type): CLIFFORD F. HUDSON FORK, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/16/59
22c. NAME OF CEMETERY OR CREMATORY: Moreland M. P.
22d. LOCATION (City, town, or county) (State): Balto. Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Legasa Funeral Home ADDRESS: 7401 Belair Rd
24a. REC'D BY REGISTRAR DATE: MAR 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3180 **CERTIFICATE OF DEATH** Reg. Dist. No. 03184

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 14 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: Coudon Farms
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Sara Middle M. Last Wright
4. DATE OF DEATH: Month March Day 24, Year 1959

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 20, 1907
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harry B. Downey
14. MOTHER'S MAIDEN NAME: Florence E. Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lewis A Wright (Husband) Address: Perryville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
331X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 23rd 19 59, to March 24th 19 59, that I last saw the deceased alive on March 24th 19 59, and that death occurred at 8:55 A M, from the causes and on the date stated above.
ACTUAL SIGNATURE: Edward Hinguis, M.D. ADDRESS (Street, city or town, state): 211 N. Union Ave. DATE SIGNED: 3/24/59 at 11 Am
PHYSICIAN'S NAME (Type): Edward C. Loo, M.D. Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-27-1959
22c. NAME OF CEMETERY OR CREMATORY: Principio Cemetery
22d. LOCATION (City, town, or county) (State): Principio Furnace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Rutherford & Sons ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58